

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR <b>Edwin L. Barham</b>					7 9 1 7 4 2 8 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Edwin L. Barham</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>7 30 79</b>			2b. HOUR <b>11:50 PM</b>		
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 23 99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Jamaica</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD.				
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Springfield Hospital Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Collector</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Med. credit</b>		
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Adrian - Barham</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leah D'Azevedo</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>078-07-8971</b>			17. INFORMANT ADDRESS <b>Records: Springfield Hospital Center</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>3352</b> IMMEDIATE CAUSE (a) <b>Bilateral massive Aortic</b> days DUE TO, OR AS A CONSEQUENCE OF (b) <b>Asymptomatic lateral Sclerosis</b> months DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>03-12</b> , 19 <b>79</b> , to <b>07-30</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>07-30</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Louder T. Saradpon, MD</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>7-30-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Louderes T. Saradpon, M.D.</b>						22e. ADDRESS <b>Springfield Hospital Center Sykesville, Maryland 21784</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>Aug. 1, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge, Howard, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>SLACK Funeral Home, Ellicott City, Maryland 21043</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 6 1979</b>				
						25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>				

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

17429

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST DAVID		MIDDLE		LAST BOERNER		2a. DATE KNOWN OF DEATH		ESTIMATED 7/26 1979		2b. MONTH DAY YEAR		2c. DATE PRONOUNCED DEAD		7/26 1979		2d. HOUR MIN.		6 05 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6/18/10		6. AGE (IN YEARS) LAST BIRTHDAY 69 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO GEN HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Line Inspector		12b. KIND OF BUSINESS OR INDUSTRY B&E		13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1011 S. Carroll St.		14. FATHER'S NAME FIRST MIDDLE LAST John C. Boerner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary H. Dehring	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW2		17. INFORMANT Mrs. Kathryn Boerner, Hampstead, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) CORONARY ARTERY DISEASE (c) 15 YEARS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1) OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Daniel I Welliver		TITLE (SPECIFY) ASSISTANT		DATE SIGNED 7/26/79		EXAMINER'S NAME (TYPE OR PRINT) DANIEL I WELLIVER MD		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-30-79		23c. NAME OF CEMETERY OR CREMATORY Grace Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Balto Md.							
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074		25a. DATE REC'D. BY REGISTRAR AUG 01 1979		25b. REGISTRAR'S SIGNATURE Richard McCready		26. DATE REC'D. BY REGISTRAR AUG 01 1979		26b. REGISTRAR'S SIGNATURE Richard McCready		26c. DATE REC'D. BY REGISTRAR AUG 01 1979		26d. REGISTRAR'S SIGNATURE Richard McCready									

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 7 4 3 0

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7 5 79		2:45 PM	
WESLEY A BOLLINGER		3 SEX		4 RACE		5. DATE OF BIRTH	
male		Cauc		MONTH DAY YEAR		11 18 05	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
USA MD		USA				Carroll MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminster		Carroll Co Gen Hosp		carpenter		Builder	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD		CARROLL		FINKSBURY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
HAYDEN		MATTIE		1725 DEER PARK RD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		216-14-6437		NACMI BOLLINGER		1725 Deer Park Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
5609		Septicemia - hyperkalemia				2 WK	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		3 WK	
		Deco-cutaneous fistula		(c)		Months	
		Intestinal obstruction					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
6/5/79		Intestinal obstruction		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 6/1/79, 19 79, to 7/5, 19 79, that (I) (the hospital) saw the deceased alive on 7/5, 19 79, and that (in my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
John Steers		MD		7/5/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			
John Steers MD		210 Washington Ave, Westminster					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		7-8-79		SMALL WOOD MTH			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert Lyle Prithard		Westminster, Md.		JUL 12 1979		Barry Holliday	

BP

08.11.19



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(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Charles Joseph Borghese</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-10-79 @</b>			2b. HOUR <b>9:45 AM</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>06-11-28</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b> MD.				
10 CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Springfield Hospital Center</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemployed</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a STATE <b>Maryland</b>			13b COUNTY <b>Baltimore</b>			13c CITY OR TOWN <b>Catonsville</b>			13d. INSIDE CITY LIMITS? YES NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Charles Borghese</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Elizabeth Meyers</b>			13e STREET ADDRESS <b>453 Cheaton Place, Baltimore 21228</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO. <b>214-26-4632</b>		17. INFORMANT ADDRESS <b>Mrs. Sandra Sohn Same</b>						

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
5070 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <b>C.O.P.D. with pulmonary fibrosis, extensive, bil.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Recurrent "aspiration" Pneumonia</b>	
		1. 1-2 years Days-years	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7-14-78</b> , 19____, to <b>7-10-79</b> , 19____, that (I) (we) last saw the deceased alive on <b>7-10-79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Octavio A. Ruiz MD</i>						22c. DATE SIGNED <b>7-10-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Octavio A. Ruiz, M.D.</b>				22e. ADDRESS <b>Springfield Hospital Center Sykesville, Maryland 21784</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 13, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 12 1979</b>	
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Robert S. BOWMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 31, 1979</b>			2b. HOUR <b>3:01 A.M.</b>							
3. SEX <b>M</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 6, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		7. MONTHS <b>7</b>		8. DAYS <b>25</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co.,</b> MD.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Operating Engineer</b>			12b. KIND OF BUSINESS OR INDUSTRY				
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. General Hospital</b>											
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Fredrick</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Route 4</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Philip T. Bowman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Beekley</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 2</b>		17. INFORMANT ADDRESS <b>Jacqueline B. Bowman, Same As #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Adenocarcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Adenocarcinoma of Thyroid</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>193-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Juan A. Suriel, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>7/31/79</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JUAN A. SURIEL</b>						22e. ADDRESS <b>CARROLL COUNTY GEN. HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug. 3, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>						
24. FUNERAL DIRECTOR NAME ADDRESS <b>Charles W. Burrier, Jr., Sykesville, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey McCreedy</b>					

The medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 7 4 3 3	
1- STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>William E. Brown</u>						2a. DATE OF DEATH MONTH DAY YEAR <u>8-20-79</u>		2b. HOUR <u>7:15 P.M.</u>			
3 SEX <u>MALE</u>		4 RACE <u>W</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>8 27 88</u>		6 AGE (IN YEARS LAST BIRTHDAY) YRS <u>90</u>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 4 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Carroll</u> MD.					
10 CITY OR TOWN OF DEATH <u>Westminster</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>WNC</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>FARMER</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>			
13a. STATE <u>MD.</u>		13b. COUNTY <u>Carroll</u>		13c. CITY OR TOWN <u>Westminster</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>PIKE 3940 LITTLESTOWN</u>			
14 FATHER'S NAME FIRST MIDDLE LAST <u>Nelson William Nelson Brown</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>ELLEN Maus Brown</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <u>NO</u>		16b. SOCIAL SECURITY NO. <u>214-32-2785</u>		17. INFORMANT <u>KENNETH D. BROWN REISTERSTOWN MD.</u>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram negative sepsis</u> <u>600-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Urinary tract infection</u> <u>chronic</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>prostatic hypertrophy</u> <u>YES</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>CVA</u>											
19a. DATE OF OPERATION <u>—</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>—</u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>—</u>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>—</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>—</u>							
22a. I certify that (1) (this hospital) attended the deceased from <u>6-9</u> 19 <u>79</u> , to <u>7-20</u> 19 <u>79</u> , that (2) (we) last saw the deceased alive on <u>7-20</u> 19 <u>79</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.											
22b. SIGNATURE <u>Alva S. Baker M.D.</u>						DEGREE <u>—</u>		22c. DATE SIGNED <u>7-20-79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Alva S. Baker M.D.</u>				22e. ADDRESS <u>19 Ridge Rd Westminster MD 21157</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>JULY 23</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARK'S CEMETERY SILVER SPRING</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>CARROLL MD.</u>					
24. FUNERAL DIRECTOR NAME <u>Richard G. Little</u>				ADDRESS <u>34 Maple Lane Littlestown Pa</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 31 1979</u>		25b. REGISTRAR'S SIGNATURE <u>History Hubing</u>			

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Handwritten notes on lined paper, including the words "FURNITURE" and "CLOTHING".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 7 4 3 4		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM TAIT CAMPBELL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>7 25 79</b>		2b. HOUR <b>7:25 PM</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 19 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VERGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL CO. MD.</b>			
10. CITY OR TOWN OF DEATH <b>SYKESVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SPRINGFIELD HOSP. CEN</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>street repairman</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>md</b>		13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>401 S. Potomac St</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JACKSON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SUSAN SAIRS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					
16b. SOCIAL SECURITY NO. <b>220-10-319</b>		17. INFORMANT ADDRESS <b>Records: Springfield Hospital Center</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4151</b> IMMEDIATE CAUSE (a) <b>pulmonary emboli</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>05-11</b> , 19 <b>76</b> , to <b>07-25</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>07-25</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. Lee M. O.</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>7-25-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Lee M. O.</b>		22e. ADDRESS <b>Springfield Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 30, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glade Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Walkersville Fred. Md.</b>			
24. FUNERAL DIRECTOR <b>G. Douglas Stauffer, Rt. 10, Frederick, Md. 21701</b>		25a. DATE <b>AUG 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 17436					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rene Ann DeCesare										2a. DATE OF DEATH MONTH DAY YEAR 7 22 79				2b. HOUR 5:50A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 8 12		6. AGE (IN YEARS LAST BIRTHDAY) 69 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NYC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.									
10. CITY OR TOWN OF DEATH Westminster MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster WMC				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md		13b. COUNTY Balt.		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks							
14. FATHER'S NAME FIRST MIDDLE LAST Louis Maelli		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Scotti		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT Joan Fentler (11-7)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram negative sepsis 5999 DUE TO, OR AS A CONSEQUENCE OF (b) Pyelonephritis Candidiasis, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Obstructive uropathy										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks Weeks Yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Multiple Sclerosis															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) (this hospital) attended the deceased from December 19 78, to 7-22 19 79, that (1) (we) last saw the deceased alive on 7-20 19 79, and that in my (a) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Alva S. Baker M.D.						DEGREE M.D.		22c. DATE SIGNED 7-22-79		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 7/25/1979		23c. NAME OF CEMETERY OR CREMATORY Lakeview Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Eldersburg Carroll Md.					
24. FUNERAL DIRECTOR Thomas D. Fletcher & Son Funeral Home						25a. DATE REC'D. BY REGISTRAR AUG 8 1979		25b. REGISTRAR'S SIGNATURE							



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 9 1 7 4 3 7			
1. DECEASED NAME (TYPE OR PRINT) <b>MINNIE C Delauter</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>July 27 79</b>			
3. SEX <b>Female</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 16 98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD.	
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Westminster Nursing + Conv. Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>MIDDLEBURG</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alfred Reno Buhrman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LuLu HAYS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-05-6292</b>		17. INFORMANT ADDRESS <b>Phyllis Buhrman Middleburg, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Concussion of Rectum</b> 1541 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 MONTH</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 10 1979</b> to <b>JULY 27 1979</b> , that (I) (we) lost saw the deceased alive on <b>JULY 27 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not view the body after death, so state.)							
22b. SIGNATURE <b>Daniel I. Welliver MD</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7-27-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL I. WELLIVER MD</b>				22e. ADDRESS <b>19 RIDGE ROAD WESTMINSTER MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-31-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARKS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westminster Frederick Md</b>	
24. FUNERAL DIRECTOR (TYPE OR PRINT) <b>Robert Kyle Smith</b> ADDRESS <b>Westminster Md</b>				25a. DATE REG'D BY REGISTRAR <b>AUG 6 1979</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 17438

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <u>JOHN DEWITT</u>			2a. DATE OF DEATH MONTH <u>7</u> DAY <u>25</u> YEAR <u>79</u>			2b. HOUR <u>6 P</u> M			
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH MONTH <u>2</u> DAY <u>18</u> YEAR <u>94</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>85</u> YRS		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>CARROLL CO</u> MD.			
10. CITY OR TOWN OF DEATH <u>SYKESVILLE</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SPRINGFIELD HOSP</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Clerical Worker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>S S Office</u>	
13a. STATE <u>MD</u> 13b. COUNTY <u>BALTO CITY</u> 13c. CITY OR TOWN <u>BALTIMORE</u> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <u>443 Rosebank Ave</u>									
14. FATHER'S NAME FIRST <u>Charles</u> MIDDLE <u></u> LAST <u>Dewitt</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Ruth</u> MIDDLE <u></u> LAST <u>MARCH</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u>		16b. SOCIAL SECURITY NO. <u>W.W. I</u>		17. INFORMANT <u>Records: Springfield Hospital Center</u> ADDRESS <u></u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4280</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>02-25</u> , 19 <u>65</u> , to <u>07-25</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>07-25</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Justin Lee, M.D.</u>				DEGREE				22c. DATE SIGNED <u>7-25-79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. Lee, M.D.</u>				22e. ADDRESS <u>Springfield Hosp. Sykesville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>			23b. DATE <u>7-27-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crematory</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR NAME <u>Ruck Towson Funeral Home, Inc.</u>				ADDRESS <u>1050 York Rd. Towson, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 27 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Justin Lee</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Kenneth Harrison Ecker</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 8, 1979</b>		2b. HOUR <b>0415 M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 29, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD.			
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bus Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School Bus</b>	
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Taneytown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Earl Ecker</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace Sauble</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-16-3100</b>		17. INFORMANT ADDRESS <b>Mrs. Joan Ecker, Walnut Grove Rd. Taneytown Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 5, 1979</b> to <b>July 8, 1979</b> , that (I) (we) last saw the deceased alive on <b>July 8, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <b>John S. Warshey, MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/8/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN S. WARSHEY MD</b>				22e. ADDRESS <b>8 Oakton St. Westminster Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 11, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Taneytown, Carroll, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Skiles Funeral Home, 136 E. Balto. St. Taneytown</b>				ADDRESS <b>Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 10 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Hester McCreedy</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 9 17440			
1. DECEASED NAME (TYPE OR PRINT) <b>EVELYN A FORD</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 31 1979</b> 2b. HOUR <b>8:30 PM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7/18/03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS. MONTHS <b>0</b> DAYS <b>13</b> HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co., MD.</b>	
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Carroll</b> 13c. CITY OR TOWN <b>Westminster</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 32</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joshua T. Barnes</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Albertha Boone</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-28-2476</b>		17. INFORMANT ADDRESS <b>121 Galewood Rd. Wylda F. Benson, Timonium, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD &amp; HYPERTENSION</b> 7 YEARS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>DIABETES MELLITUS</b> 7 YEARS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>DEC 19 76</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 31 1979</b> to <b>JULY 31 79</b> , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive and (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <b>Daniel Welliver MD</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7-31-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL WELLIVER</b>				22e. ADDRESS <b>19 RIDGE ROAD WESTMINSTER MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 2, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Providence</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Gamber, Carroll, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Charles W. Burrier, Jr., Sykesville, Md.</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>AUG 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				9 17441 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ERMA GRACE FUNK				2a. DATE OF DEATH MONTH DAY YEAR 7 30 79				2b. HOUR 12 38 M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN 7 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL CO. MD.					
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO. GENERAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MEDICAL SECTY.		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL			
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN REISTERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 103 BROOKEBURY DR.			
14. FATHER'S NAME FIRST MIDDLE LAST S. FRANK SCHLICHTER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE ECKENRODE				ADDRESS 229 NORTHWAY RD. REISTERSTOWN, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-22-4347		17. INFORMANT R. EUGENE FUNK							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ASD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-30-1979, to 7-30-1979, that (I) (we) lost saw the deceased alive on 7-30-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Chitrache Du Naganana MD						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHE DU NAGANNA						22e. ADDRESS 174 E Main St. Westminster MD 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG 1 1979		23c. NAME OF CEMETERY OR CREMATORY NORLAND CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CHAMBERSBURG PA.					
24. FUNERAL DIRECTOR NAME H J Eshardt						ADDRESS Owings Mills, Md.		25a. DATE REC'D. BY REGISTRAR AUG 1 1979		25b. REGISTRAR'S SIGNATURE	

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 1 7 4 4 2	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST E. Tyson HARDEN					2a. DATE OF DEATH MONTH DAY YEAR July 31 1979			2b. HOUR A M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 27 1910		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 209 BEZOLD AVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY GAS & ELECTRIC			
13a. STATE Md		13b. COUNTY CARROLL		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 209 BEZOLD AVE			
14. FATHER'S NAME FIRST MIDDLE LAST MAULDER S. HARDEN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAUDE Taylor						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) NONE		17. INFORMANT MARY HILL HARDEN		ADDRESS Westminster Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2898 Acute respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute myeloclosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from October 4, 19 72, to July 31, 19 79, that (I) (we) lost saw the deceased alive on July 31, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Naci N. Buyukunsal, M.D.					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-31-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Naci N. Buyukunsal, M.D.					22e. ADDRESS Sykesville, Maryland 21784						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-2-79		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg CARROLL Md				
24. FUNERAL DIRECTOR NAME Robert Kyle Pitts Jr. Westminster, Md.					25a. DATE REC'D. BY REGISTRAR AUG 3 1979		25b. REGISTRAR'S SIGNATURE Ruthy McCarney				

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										17443 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edwin Ely Harrison										2a. DATE KNOWN OF DEATH ESTIMATED 2b. HOUR 2c. DATE PRONOUNCED DEAD 2d. HOUR	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 17 1895		6. AGE (IN YEARS) LAST BIRTHDAY 84 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10. CITY OR TOWN OF DEATH Hampstead				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18134 Gunpowder Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office American Standard		12b. KIND OF BUSINESS OR INDUSTRY Standard	
13a. STATE Maryland				13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Hampstead 21074 18134 Gunpowder Road	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Harrison						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roxey Mathaney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-10-6781		17. INFORMANT Daughter: Jackie Schultheis ADDRESS Balt., Md. 21222 400 Westfield Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized ASCVD</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>and Dehydration</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-yr	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Charles F. Donnell</u>				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER		DATE SIGNED 7/14/79	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 17 1979		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.						ADDRESS Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JUL 17 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION



Handwritten notes and stamps at the top of the page, including a date stamp that appears to read "JUN 19 1964".

Main body of the document containing several paragraphs of handwritten text, some of which are crossed out with diagonal lines.

Handwritten notes and stamps at the bottom of the page, including a date stamp that appears to read "JUN 19 1964".

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 7 4 4 4

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>William Leslie Hoffman</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>July 1 1979</b>		2b. HOUR <b>5 P M</b>	
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 29 1904</b>	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>150 Hook Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>INSURANCE</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>Westminster</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William F. Hoffman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha M. Arnold</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>213-05-1184</b>		17. INFORMANT <b>Ralph Hoffman</b>		17. ADDRESS <b>Westminster, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Myocardial Infarction</b> 410- DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>79</b> to <b>July</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>July 1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Daniel F. Welliver</b>		DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL F. WELLIVER</b>		22e. ADDRESS <b>19 Ridge Rd. Westminster, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7-5-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DEER PARK</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westminster, Carroll, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 13 1979</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert L. Smith &amp; Co. Westminster, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

1 7 4 4 5

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST G. Robert Hook			2a. DATE OF DEATH MONTH DAY YEAR 7-29-79		2b. HOUR 0609 M
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12 6 1906		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD	
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL Co. General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER	12b. KIND OF BUSINESS OR INDUSTRY FARM	
13a. STATE Md			13b. COUNTY CARROLL	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE R. Hook			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSSIE R. HELM		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT ADDRESS MRS. Otisida Hook Westminster, Md	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> 2500 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } gave rise to immediate } cause (a), stating the } underlying cause lost. } (b) <u>diabetes mellitus</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION 7/29		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/28</u> , 19 <u>79</u> , to <u>7/29</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>7/29</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Paul W. Genshade</u>		DEGREE MD		22c. DATE SIGNED 7/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Kyle Pruthi		22e. ADDRESS Westminster, Md.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-1-79	23c. NAME OF CEMETERY OR CREMATORY St. Marys		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Run Carroll Md	
24. FUNERAL DIRECTOR NAME Robert Kyle Pruthi		ADDRESS Westminster, Md.		25a. DATE REC'D. BY REGISTRAR AUG 6 1979	25b. REGISTRAR'S SIGNATURE <u>Marky McBrady</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edmund Allen Jewett						2a. DATE OF DEATH MONTH DAY YEAR July 25, 1979		2b. HOUR 10:30a M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 30, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3010 Bird View Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Building Supply	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Carroll Westminster						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3010 Bird View Road	
14. FATHER'S NAME FIRST MIDDLE LAST Roland C. Jewett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Ray					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korean 216-24-7215		17. INFORMANT ADDRESS Laura M. Jewett 3010 Bird View Rd., Westminster, Md.					
18. CAUSE OF DEATH Enter only one cause per line for 18a, 18b, and 18c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Cardio-Respiratory Failure</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Generalized Metastases</u> (c) <u>Carcinoma of the Lung</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 59 14 mo. 39								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>Sept. 26, 1979</u> to <u>July 25, 1979</u> , that (1) (we) lost saw the deceased alive on <u>3/25/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) had not seen the body after death.									
22b. SIGNATURE <u>George Richards, Jr.</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/25/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Richards, Jr.				22e. ADDRESS Greater Balto. Medical Center, Balto., Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE July 27, 1979		23c. NAME OF CEMETERY OR CREMATORY WestviewMem. Park		23d. LOCATION BALTIMORE, MARYLAND CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR <u>H. J. Schaubert</u>				ADDRESS Owings Mills, Md.		25a. DATE OF DEATH JUL 25 1979		25b. SIGNATURE <u>George Richards, Jr.</u>	



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17447

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OF PRINT) FIRST MIDDLE LAST <i>Gladys Evelyn Johnson</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>7 20 1979</i>		
3. SEX <i>F.</i>	4. RACE <i>W.</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>4 2 13 66</i>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <i>66</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <i>66</i>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>7 20 1979</i>
7b. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Sykesville</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Springfield Hosp. Center</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll County</i>	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <i>MD.</i> 12a. COUNTY <i>Baltimore</i> 12c. CITY OR TOWN <i>Owings Mills</i>			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic Worker</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Edward Lee Johnson</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Myrtle Damon</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>218-18-6337</i>		17. INFORMANT ADDRESS <i>Mr. John Johnson 10111 Barnes Rd., Owings Mills, MD 21117</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <i>Complicated by Diabetes Mellitus</i> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Richard A. Jones</i>		TITLE (SPECIFY) <i>Deputy</i>		DATE SIGNED <i>21 Jul 79</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>Richard A. Jones</i>		ADDRESS <i>Carroll County General Hosp. Wetmore St.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>7/24/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lakeview Memorial Park</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Sykesville Carroll MD</i>		24. FUNERAL DIRECTOR NAME <i>Loring Byers Funeral Directors, P.A.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 23 1979</i>	
25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i>					



Washington, D.C.

April 10, 1918

My dear Mr. [illegible]:

[illegible]

[illegible signature]

Very truly yours,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 7 4 4 8 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST William		MIDDLE J.		LAST Johnson		2a. DATE OF DEATH MONTH DAY YEAR 07-06-79	
3 SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 05 16 02		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		2b. HOUR A 8:45 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEP. DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) contractor		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3710 Liberty Heights Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Susie Jason		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frank Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-16-9678		17. INFORMANT ADDRESS Records, Springfield Hospital Center					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: _____ years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10-10</u> 19 <u>76</u> to <u>07-06</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>07-06-19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>D. Antonini Graeme</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>7/6/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/13/79		23c. NAME OF CEMETERY OR CREMATORY KING MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO. MD.			
24. FUNERAL DIRECTOR NAME Wm. C. March				ADDRESS F/H 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUL 13 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony K. Brady</u>	

VI-20-75

Section 1

Section 2

IV

West

East

Section 1

Section 2

Section 3

Section 4

Section 1

Section 2

Section 3

Section 1

Section 2

Section 3

Section 4

Section 5

Section 1

Section 2

Section 3

Section 4

Section 1

Section 2

Section 1

Section 1

Section 2

Section 3

Section 4

Section 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7-9 17449	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH G. JONES			2a. DATE OF DEATH JULY 17, 1979		2b. HOUR 8 P. M.
3 SEX Female	4 RACE White	5. DATE OF BIRTH May 20, 1888	6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH Finksburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2604 Old Westminster Pike		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE Md.		13b. COUNTY Carroll	13c. CITY OR TOWN Finksburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME Lawrence			15. MOTHER'S MAIDEN NAME Catherine Winter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213 74 5980		17. INFORMANT ADDRESS Mrs. Margaret Peterson Lutherville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from November 19, 76, to July 17, 1979, that (I) (we) last saw the deceased alive on May 15, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE L. E. Saylor M.D.				22c. DATE SIGNED 7/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lloyd E. Saylor, M.D.				22e. ADDRESS 3902 Greenmount Ave. Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-20-79		23c. NAME OF CEMETERY OR CREMATORY Loudon Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212			
25a. DATE REC'D. BY REGISTRAR JUL 20 1979				25b. REGISTRAR'S SIGNATURE [Signature]	

88-11-27



MAILED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

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(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 17450	
1. FOR STATE REGISTRAR			REG. NO.								
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Michael Joseph Kittelberger						7/4/79			1905 M		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		white		7 4 79		0 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Westminster Maryland		U.S.A.				Carroll County MD.					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Westminster			Carroll Co. Gen'l Hospital								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Joseph C. Kittelberger			Carolyn E. Cole								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS						
					Mr. Joseph C. Kittelberger, Hampstead, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Immaturity</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
7611 DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Maternal Rupture of Membranes</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>7/4</i> , 19 <i>79</i> , to <i>7/4</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>7/4</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i> DEGREE										22c. DATE SIGNED <i>7/4/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			7-6-79		Grace Cemetery		Hampstead Balto Md.				
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Eline Funeral Home, Hampstead, Md. 21074						JUL 9 1979		<i>[Signature]</i>			

COPIES



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					7 9 1 7 4 5 1 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>Margaret S Lentzner</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>7 18 79</b>						
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 12 91</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>88</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Reisterstown</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Westminster Merg &amp; Convalescent</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md</b>					13b. COUNTY <b>Balt.</b>		13c. CITY OR TOWN <b>Reisterstown</b>		13d. STREET ADDRESS <b>356 Main St</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Christian Lentzner</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary b. Horase</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/>					16b. SOCIAL SECURITY NO. <b>213-10-6645</b>		17. INFORMANT <b>William G. Lentzner</b>			ADDRESS <b>7 Austin Road Reisterstown, Md. 21136</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b> <b>Years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>July 20 1975</b> to <b>July 18 1979</b> , that (I) (we) lost saw the deceased alive on <b>July 17 1979</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>C. F. Williams</b>					DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <b>7-18-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. F. Williams</b>					22e. ADDRESS <b>11904 Reisterstown Rd Reisterstown Md 21136</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>July 20, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Reisterstown Methodist</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Reisterstown, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Eline Funeral Home, Reisterstown, Md.</b>					ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCready</b>		

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Irwin A. McGee</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>7 1 79</b>		2b. HOUR <b>10 45 AM</b>		
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 13 1911</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD.			
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>946 Washington Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Trucking Business</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employ.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Westminster</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>946 Washington Road</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Lee A. McGee</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Hosfeld</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR OR DATES) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>218 32 3617</b>		17 INFORMANT ADDRESS <b>Mrs Margaret L. McGee Same as # 13</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG &amp; CEREBRAL METASTASES</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <b>69</b> , to _____, 19 _____, that (I) (we) lost saw the deceased alive on <b>6/22</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Vincent J. Fiocco</i> MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7/1/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Vincent J. Fiocco</b>				22e. ADDRESS <b>8 Anchor St. Westminster, Md. 21157</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/3/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Finksburg Carroll Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Thomas D. Fletcher &amp; Son Funeral Home</b>				24b. ADDRESS <b>254 E. Main St. Westminster Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 6 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Richard McCreedy</i>	

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Notes

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White

Male

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W. S. A.

Very young

Control

Working business with family.

215 Washington Road

Washington

X 215 Washington Road

Washington

Control

Very young

Home

Home

Home

A.

Yes

215 13 3011 The University of Washington

215 13 3011

W. S. A.

Yes

Anchor St. Washington, D. C. 20001

Anchor St. Washington

Control

Evergreen Nat. Garden, University

W. S. A.

Female

215 13 3011 The University of Washington

215 13 3011 The University of Washington

## REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Gladys E. Melown		7-24-79		0425M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	June 3 1897	82	MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Carroll MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Westminster	Carroll County General Hospital		Genecso Corp.		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Carroll	Westminster	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	36 Carroll Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
James W. Melown		Lillie E. Sheets			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
No		213 09 5383	1010 Valen Road Robert W. Melown Westminster, Md. 21157		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1534 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma</u>					<u>hr.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of stomach</u>					<u>hr.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/28/79</u> , 19 <u>79</u> , to <u>7/24</u> , 19 <u>79</u> , that (I) <u>have</u> lost saw the deceased alive on <u>7/23</u> , 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.					
22b. SIGNATURE		DEGREE	ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
<u>Robert F. Bell</u>		<u>M.D.</u>			<u>7/24/79</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Robert F. Bell		187 E. Main St. Westminster, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	7/26/1979	Westminster Cemetery	Westminster Carroll Md.		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
Thomas D. Fletcher & Son Funeral Home		MD. AUG 8 1979	<u>Anthony McBrady</u>		

## MEDICAL CERTIFICATION

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Robert S. Inoué

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 17454

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Laura E Miller			2a. DATE OF DEATH MONTH DAY YEAR July 5 1979		2b. HOUR 6 A M
3. SEX female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug 15 1907		6. AGE (YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD		
10. CITY OR TOWN OF DEATH Manchester	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) (Home) 10 N. Main St		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Sewing factory
13a. STATE Md	13b. COUNTY Carroll	13c. CITY OR TOWN Manchester	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 10 N. Main St	
14. FATHER'S NAME FIRST MIDDLE LAST Henry F. Bailey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie M. Frank			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-14-1267		17. INFORMANT Donald Miller 10 N. Main St, Manchester, Md 21102	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Arrhythmia</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 77
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Hypertension - Diabetes mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from Feb 19 1948, to July 5 1979, that (1) (we) last saw the deceased alive on Feb 27 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W H Foard MD		DEGREE		22c. DATE SIGNED 7/5/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W H Foard MD		22e. ADDRESS 25 N. Main St Manchester Md 21102			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-7-79		23c. NAME OF CEMETERY OR CREMATORY Alesia Cemetery	
23d. LOCATION CITY OR TOWN Millers		COUNTY Carroll		STATE Md.	
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074		ADDRESS 21074		25. DATE REC'D. BY REGISTRAR JUL 9 1979	
25. REGISTRAR'S SIGNATURE [Signature]					

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W. H. ...  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 7 4 5 5		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN S. MURRAY				2a. DATE OF DEATH MONTH DAY YEAR July 30, 1979		2b. HOUR A.M. 10:45			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 9, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CARROLL MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Gen. Hospt.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Balto. City Fire Dept.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 536 Shirley Manor Road	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Murray				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-09-5484		17. INFORMANT ADDRESS Mrs. Katherine M. Murray Reisterstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular tachycardia</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASVD.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7-24-</u> 19 <u>79</u> , to <u>7-30-</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>7-30-</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Glenn H. Hagan</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Glenn H. Hagan</u>				22e. ADDRESS 174 E Main St Westminster MD 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 2, 1979		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville, Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home Reisterstown, Md. 21136				ADDRESS		25a. DATE RECEIVED BY REGISTRAR 7/30/79			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 1 7 4 5 6 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>Lewis E. Nussear</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>7 21 79</b>					2b. HOUR <b>0016A</b>
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 7 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b>				
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Co.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Finksburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lewis E. Nussear</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Myrtle (Cornwell) Nussear</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>132-01-7902</b>		17. INFORMANT ADDRESS <b>Mrs. Helen H. Nussear</b>		17b. STREET ADDRESS <b>3810 Tupelo Rd. Finksburg, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>anterior wall myocardial infarction</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>diabetes mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>hypertension</b>										
19a. DATE OF OPERATION <b>7/21/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>7/19/79</b> to <b>7/21/79</b> , that (I) (we) lost saw the deceased alive on <b>7/21/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE <b>John W. Spence</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>7/21/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/24/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Reisterstown Methodist</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Reisterstown Balto. Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Eline Funeral Home, 11824 Reisterstown Rd.</b>				25. DATE REC'D. BY REGISTRAR <b>JUL 24 1979</b>						

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Table 1. *Continued*

Figure 2. *Staphylococcus aureus* strains.

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Journal of Interpersonal Violence 26(10)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 17457

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		2b. HOUR	
H. Lester Phelps				July 6, 1979		9:45 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS, LAST BIRTHDAY)	
Male		White		MONTH DAY YEAR		78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.		U. S. A.				CARROLL MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminster		Westminster Nursing Home		Clerk		State Hospital	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		CARROLL		Sykesville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		7322 Springfield Ave			
Harry Phelps		Mary H. Barnes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
No		283 12 3733		Maude Phelps		Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Diffuse carcinomatosis, small spindle cell							
1533 DUE TO, OR AS A CONSEQUENCE OF (b)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
Chronic obstructive pulmonary disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
6/18/79		Cancer of Sigmoid Colon		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/2, 19 79, to 7/6, 19 79, that (I) (we) lost saw the deceased alive on 7/6, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Norman A. Poulsen		MD		7/6/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
NORMAN A. POULSEN		19 RIDGE RD. WESTMINSTER, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		7-4-79		Springfield Cemetery		Sykesville Carroll Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Harry W. Haight		Sykesville, Md.		JUL 18 1979			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		79 17458 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST WILLIAM R		MIDDLE		LAST PHILLIPS		2a. DATE OF DEATH MONTH DAY YEAR JULY 18 1979		2b. HOUR 10 MIN A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 7 1911		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED * NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Nursing & Conv. Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Roller		12b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
13a. STATE Md.						13b. COUNTY Balto		13c. CITY OR TOWN Upperco		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William R. Phillips						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Gifford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-7552		17. INFORMANT ADDRESS Mrs. Evelyn Phillips, Upperco, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1889 IMMEDIATE CAUSE (a). CARCINOMA OF URINARY BLADDER WITH LUNG METASTASIS DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from JULY 9 1979, to JULY 18 1979, that I (we) lost saw the deceased alive on JULY 18 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Daniel I. Welliver M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-18-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER M.D.		22e. ADDRESS 14 RIDGE ROAD WESTMINSTER, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-21-79		23c. NAME OF CEMETERY OR CREMATORY Trenton Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Upperco Balto Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074				25a. DATE REC'D. BY REGISTRAR JUL 23 1979		25b. REGISTRAR'S SIGNATURE Kristy McCready					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 7 4 5 9 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>ARCHIE EDWARD PICKETT</b>					2a. DATE OF DEATH MONTH <b>7</b> DAY <b>3</b> YEAR <b>79</b>			2b. HOUR <b>11:55 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>6</b> YEAR <b>1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		IF UNDER 1 YEAR MONTHS <b>9</b> DAYS <b>27</b> IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co., MD.</b>			
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Woodbine</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Hoods Mill Road</b>	
14. FATHER'S NAME FIRST <b>Harry</b> MIDDLE <b>E.</b> LAST <b>Pickett</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Grace</b> MIDDLE <b>M.</b> LAST <b>Ridgley</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO <b>WW 2</b>		17. INFORMANT ADDRESS <b>Box 5619 Mrs. Samuel G. Pickett, Woodbine, Md.</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Ca</b> <b>1869</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Probably Testicular Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Obstructive Pul. Dis.; Anemia; ASHO-</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/25</b> , 19 <b>79</b> , to <b>7-3</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>7-3</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>M. Seville</b> DEGREE <b>MD.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <b>7-3-79</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARQUEZ J. SEVILLE, MD.</b>					22e. ADDRESS <b>419 C Malcolm Dr. WESTMINSTER, N.J.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-6-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Morgan Chapel</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Carroll, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Charles W. Burrier, Jr., Sykesville, Md.</b> ADDRESS <b></b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 9 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 7 4 6 0

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
Hazel Catherine Replogle		July 13, 1979		9:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	05-03-99	80	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	
Colorado		U.S.A.		Carroll County, Sykesville, MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville	Springfield Hospital Center		Housewife	own home	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2305 Darrow Street
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
(unknown)		Lydia		(unknown)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		213-38-2178		Records, Springfield Hospital Center	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) Senile dementia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7-12-71, 19, to 7-13-79, 19, that (I) (we) last saw the deceased alive on 7-13-79, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Dr. Antonius Glahn		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		xx 13-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Antonius Glahn, M.D.		Springfield Hospital Center Sykesville, Maryland 21784			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	
Burial		7-14-1979	Fort Lincoln	Brentwood Pr. Georges Md.	
24. FUNERAL DIRECTOR					
Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.					

JUL 17 1979



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17461	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <u>LOYD THOMAS RICE</u>										2a. DATE KNOWN OF DEATH <u>7 20 1979</u>	
3. SEX <u>MALE</u> 4. RACE <u>WHITE</u> 5. DATE OF BIRTH <u>SEPT 18 1911</u> 6. AGE (IN YEARS) <u>67</u> YRS.										2b. DATE OF DEATH <u>7 20 1979</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>W. Va.</u> 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD <u>7 20 1979</u>	
9. BALTIMORE CITY OR COUNTY OF DEATH <u>CARROLL</u>										12b. KIND OF BUSINESS OR INDUSTRY <u>TOOLS</u>	
10. CITY OR TOWN OF DEATH <u>HAMPSTEAD</u> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>3542 BASLER RD.</u> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>MACHINIST</u>											
13a. STATE <u>MD</u> 13b. COUNTY <u>CARROLL</u> 13c. CITY OR TOWN <u>HAMPSTEAD</u> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET ADDRESS <u>3542 BASLER RD.</u>	
14. FATHER'S NAME FIRST <u>THOMAS</u> MIDDLE <u>?</u> LAST <u>RICE</u> 15. MOTHER'S MAIDEN NAME FIRST <u>MARY</u> MIDDLE <u>L.</u> LAST <u>HICKMAN</u>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>NO</u> 16b. SOCIAL SECURITY NO. <u>235-18-1741</u> 17. INFORMANT <u>HILDA RICE</u> ADDRESS <u>3542 BASLER RD. HAMPSTEAD, Md.</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>492- Atherosclerotic Cardiovascular Disease</u> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Complicated by Emphysema and</u> DUE TO OR AS A CONSEQUENCE OF (c) <u>Chronic obstructive pulmonary disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Richard A. Jones</u> M.D. TITLE (SPECIFY) MEDICAL EXAMINER DATE SIGNED <u>205 Jul 79</u>											
EXAMINER'S NAME (TYPE OR PRINT) <u>RICHARD A. JONES</u> ADDRESS <u>425 WARFIELDsBURG RD.</u>										WESTMINSTER, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> 23b. DATE <u>7/24/79</u> 23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u> 23d. LOCATION CITY OR TOWN <u>Balto.</u> COUNTY <u>Md.</u> STATE <u>Md.</u>											
24. FUNERAL DIRECTOR NAME <u>H. J. Eckhardt</u> ADDRESS <u>Manchester, Md.</u> 25a. DATE RECD. BY REGISTRAR <u>JUL 25 1979</u> REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 9		17462	
1. DECEASED NAME (TYPE OR PRINT) Theodore McKinley Robinson				2a. DATE OF DEATH MONTH DAY YEAR 7-24-79		2b. HOUR 7:55 A.M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 10 31 03		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10 CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) lumber yard		12b. KIND OF BUSINESS OR INDUSTRY Laborer	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Towson	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 308 Linden Terrace			
14. FATHER'S NAME FIRST MIDDLE LAST John Ulysses Robinson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Alice Lawrence			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-05-6909		17. INFORMANT ADDRESS Records, Springfield Hospital Center			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>probably 20 to M.I.</u> (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes minutes							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>05-29</u> , 19 <u>39</u> , to <u>07-24</u> , 19 <u>79</u> , that (I) <u>was</u> last saw the deceased alive on <u>07-24</u> , 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) (did not) view the body after death.							
22b. SIGNATURE <u>Loures T. Saradon</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7-24-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Loures T. Saradon, M.D.</u>				22e. ADDRESS Springfield Hospital Center Sykesville, Maryland 21784			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 26, 1979		23c. NAME OF CEMETERY OR CREMATORY DEER CREEK MEB CH. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Forest Hill, Harford Co. Maryland 21050	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> <u>Bel Air, Maryland 21014</u>				25a. DATE REC'D. BY REGISTRAR JUL 27 1979		25b. REGISTRAR'S SIGNATURE <u>John J. [Signature]</u>	

BP





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

WILLIAM SANDERS 63

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William Sanders			2a. DATE OF DEATH MONTH DAY YEAR 7 2 79			2b. HOUR 6 45 PM			
3. SEX M.		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8 29 05		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unknown		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hosp Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 906 Farnham Ave	
14. FATHER'S NAME FIRST MIDDLE LAST SANDERS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TRAMMELL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 5717-14-7050		17. INFORMANT ADDRESS Records, Springfield Hospital Center					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular disease

4593

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-2, 1979, to 7-2, 1979, that (I) (we) lost saw the deceased alive on 7-2, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jae M. Park MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7-2-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAE M. PARK MD				22e. ADDRESS Springfield Hosp Center Sykesville Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 6, 1979		23c. NAME OF CEMETERY OR CREMATORY Washington National Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis P.D. Md	
24. FUNERAL DIRECTOR NAME Takoma Funeral Home 14600				ADDRESS 254 Carroll BLVD		25a. DATE REC'D. BY REGISTRAR (IS REGISTRAR'S SIGNATURE) JUL 5 1979	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CONVOLUTION FIBER



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Main body of the document containing faint, mostly illegible text and markings, possibly a form or report.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP  
DHMH - 17  
(VR AT 5 ME (5))  
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17464	
1. DECEASED NAME (TYPE OR PRINT) <b>Howard Joseph Stonesifer</b>										2b. DATE KNOWN OF DEATH ESTIMATED <b>7 20 1979</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>July</b> DAY <b>16</b> YEAR <b>1902</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>77</b> YRS.	IF UNDER 1 YR. MONTHS <b>7</b> DAYS <b>20</b> HOURS <b>19</b> MIN.	IF UNDER 24 HRS. MONTHS <b>7</b> DAYS <b>20</b> HOURS <b>19</b> MIN.	7c. DATE PRONOUNCED DEAD <b>7 20 1979</b>		7d. HOUR <b>10</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b>					
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Furniture Repairman</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Westminster</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>18 Penna. Ave.</b>			
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>W.</b> LAST <b>Stonesifer</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Jennie</b> MIDDLE <b>A.</b> LAST <b>Boose</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Doris S. Weller</b>				ADDRESS <b>170 Willis Street Westminster, Md.</b>				APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH			
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Associate with Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH <b>4292</b> <b>4292</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Richard A. Jones</b>				TITLE SPECIFY <b>Deputy</b>				DATE SIGNED <b>20 Jul 79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Richard A. Jones</b>				ADDRESS <b>Carroll County Gen. Hosp. Westminster</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>7/21/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process Inc.</b>		23d. LOCATION CITY OR TOWN <b>Catonsville</b> COUNTY <b>Baltimore</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Thomas D. Fletcher &amp; Son Funeral Home</b> ADDRESS <b>254 E. Main St. Westminster Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 08 1979</b>				25b. REGISTRAR'S SIGNATURE <b>Patricia McBrady</b>			

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DHMH - 17  
(VR AT 5 ME (5))  
15M 7/77



Male White July 16, 1901 77

Maryland U.S.A. Carroll

Westminster Carroll County General Hospital

Dr. J. H. Carroll

John U.S.A. Carroll  
170 W. Main St., Westminster, Md.  
The Johns Hopkins Hospital, Baltimore, Md.

Carroll County General Hospital  
Westminster, Md.  
The Johns Hopkins Hospital, Baltimore, Md.  
The Johns Hopkins Hospital, Baltimore, Md.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 7 4 6 5	
1. DECEASED NAME (TYPE OR PRINT) <u>Theodore Russell Troxell</u>						2a. DATE KNOWN OF DEATH ESTIMATED <u>7 24 1979</u>		2b. HOUR OF DEATH <u>7 24</u>		2c. DATE PRONOUNCED DEAD <u>7 24 1979</u>	
3. SEX <u>Male</u>		4. RACE <u>Cau.</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Sept. 22, 1923</u>		6. AGE (IN YEARS) LAST BIRTHDAY <u>52</u> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7. DATE PRONOUNCED DEAD <u>7 24 1979</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>				7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Carroll,</u>	
10. CITY OR TOWN OF DEATH <u>Westminster</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Carroll Co. Gen. Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Md. Co-Op. Milk Prd.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13a. STATE <u>Maryland</u>				13b. CITY OR TOWN <u>Frederick</u>		13c. CITY OR TOWN <u>Thurmont</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>11316 Hessong Bridge Rd.</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>George Russell Troxell</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mable Grave Wastler</u>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>Yes</u>			
16b. SOCIAL SECURITY NO. <u>219-20-1153</u>				17. INFORMANT <u>Mrs. Lois Jean Troxell Thurmont, Md. 21788</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cobalt Radiation</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Richard A. Jones</u>				TITLE (SPECIFY) <u>Physician</u>				DATE SIGNED <u>24 Jul 79</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>Richard A. Jones, M.D.</u>				ADDRESS <u>Westminster, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>7-27-1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Apples Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Thurmont, Frederick, Maryland</u>			
24. FUNERAL DIRECTOR <u>Robert E. Dailey &amp; Son</u>				ADDRESS <u>615 East Main Street Thurmont, Md. 21788</u>				25a. DATE REC'D. BY REGISTRAR <u>JUL 30 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Robert E. Dailey</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for notification.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 7 4 6 6		REG. NO.							
1 DECEASED NAME (TYPE OR PRINT)			FABER GLENN TRUMP			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
3 SEX			4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS.		
male			cauc.		6 2 31		48 YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Finksburg		USA				Carroll MD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Finksburg		2738 Cederhurst Rd.				unemployed					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Carroll		Finksburg		YES <input type="checkbox"/> NO <input type="checkbox"/>		2738 Cederhurst Rd.			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST			FIRST MIDDLE LAST								
Clarence C. Trump St.			Annie Smith								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS						
No			212-24-6855		Mrs. Bertha Turnbaugh Finksburg, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2859 IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>? Anemia</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
<i>Dean H. Griffin</i>						M.D.			7-18-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Dean H. Griffin, M.D.						Westminster, Maryland 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			July 21, 79		Finksburg Cemetery		Finksburg, Md.				
24 FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Eline Funeral Home Reisterstown, Md. 21136						JUL 23 1979		<i>John H. Brady</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 17467	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JEANETTE SUSAN WAGNER					2a. DATE OF DEATH MONTH DAY YEAR July 8, 1979			2b. HOUR 2249			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 25 1899		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CARL MO.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.					
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) Carroll Co. Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. STATE MO.		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 68 W. Green St.			
14. FATHER'S NAME FIRST MIDDLE LAST WALTER C COOK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WIVIE ST. HIEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-05-795		17. INFORMANT ADDRESS JEANETTE ROSE 68 W. Green St.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Progressive Cerebrovascular insufficiency</u> 4370 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>July 3, 1979</u> to <u>July 8, 1979</u> , that (I) (we) last saw the deceased alive on <u>July 8, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John S. Harshey, M.D.</u> DEGREE					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 7/8/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HARSHEY, M.D.					22e. ADDRESS 8 Anchor St. Westminster, Md. 21157						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/11/79		23c. NAME OF CEMETERY OR CREMATORY KRIEDERS		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll MO.				
24. FUNERAL DIRECTOR NAME Robert E. Potts					ADDRESS 91 Wills St. Westminster		25a. DATE REC'D. BY REGISTRAR JUL 12 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy		

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1- FOR  
STATE  
REGISTRAR.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 7 4 6 8

1. DECEASED NAME (TYPE OR PRINT) WALTER PICKETT WANTZ			2a. DATE OF DEATH MONTH DAY YEAR July 28, 1979			2b. HOUR 12:40 AM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Nov 17 1908	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.				
10. CITY OR TOWN OF DEATH NEW WINDSOR	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 405 CHURCH ST.		12a. USUAL OCCUPATION (GIVE FULL NAME OF WORKING LIFE) INSPECTOR		12b. KIND OF BUSINESS OR INDUSTRY DAIRY PROD.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY CARROLL	13c. CITY OR TOWN NEW WINDSOR	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 405 CHURCH ST.	
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD M WANTZ			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE - PICKETT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NO		17. INFORMANT 405 CHURCH ST. ELIZABETH WANTZ NEW WINDSOR MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA - URINARY bladder 1889 } DUE TO, OR AS A CONSEQUENCE OF with bony metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CORONARY heart disease - years.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Feb. 1979
19a. DATE OF OPERATION 3/1/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. - bladder		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER))		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 26, 1962, to Now, 1979, that (I) (we) lost saw the deceased alive on July 27, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. Caricofe MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/28/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. CARICOFE M.D.				22e. ADDRESS Union Bridge, Md 21791			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 30, 1979		23c. NAME OF CEMETERY OR CREMATORY KREIDERS CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE WESTMINSTER MD	
24. FUNERAL DIRECTOR NAME D D Hartzler				ADDRESS New Windsor MD		25a. DATE REC'D. BY REGISTRAR JUL 31 1979	
				25b. REGISTRAR'S SIGNATURE Lester Halbur			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 7 4 6 9

1. DECEASED NAME (TYPE OR PRINT) Thomas V. Wertz			2a. DATE OF DEATH MONTH DAY YEAR 7-25-79		2b. HOUR 0530 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 14, 1900	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.		
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Motorman		12b. KIND OF BUSINESS OR INDUSTRY Transportation
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Carroll	13c. CITY OR TOWN Hampstead	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 4818 Westfield Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas A. Wertz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 180-09-4120	17. INFORMANT 4818 Westfield Drive, Donald Wertz, Hampstead, Md. 21074		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 436- DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 6-27-79, 1979, to 7-25-1979, that (I) (we) lost saw the deceased alive on 7-24-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

22b. SIGNATURE Chitrachedu Naganna	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7/25/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chitrachedu Naganna	22e. ADDRESS Carroll Co. Gen'l Hosp. Westminster Md.		

23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial	23b. DATE 7-28-1979	23c. NAME OF CEMETERY OR CREMATORY New Freedom Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE New Freedom York Penna.
24. FUNERAL DIRECTOR Hartenstein New Freedom, Penna.		25a. DATE RECEIVED BY REGISTRAR JUL 30 1979	25b. REGISTRAR'S SIGNATURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 7 4 7 0

1. DECEASED NAME (TYPE OR PRINT) Paul Henry Wildisan			2a. DATE OF DEATH MONTH DAY YEAR July 4, 1979			2b. HOUR 9 a M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 7, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.			
10. CITY OR TOWN OF DEATH Finksburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2201 Old Westminster Pike #6		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Milk			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Finksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Trailer # 6 2201 Old Westminster Pike.	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Wildisan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma C.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-24-9834		17. INFORMANT ADDRESS. Paul P. Wildisan 114 Miami Ave., Westminster, Md. 21157					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - acute</u> 410 - DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis - generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day - 9 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-13</u> , 19 <u>75</u> , to <u>7-4</u> , 19 <u>79</u> . That (I) (we) last saw the deceased alive on <u>6-20</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <u>C. E. McWilliams</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>7-5-79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clarence E. McWilliams				22e. ADDRESS Reisterstown Rd., Reisterstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 7, 1979		23c. NAME OF CEMETERY OR CREMATORY Meadowbranch Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster, Carroll, Md.			
24. FUNERAL DIRECTOR NAME <u>H. Ehlhardt</u>				ADDRESS Owings Mills, Md.		25a. DATE REC'D. BY REGISTRAR JUL 9 1979		25b. REGISTRAR'S SIGNATURE <u>H. Ehlhardt</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ALBERTA ELWORTH WOODYARD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 19 79</b>		2b. HOUR <b>8 55 A M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH DAY MONTH YEAR <b>12 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CARROLL</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL</b> MD.	
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARROLL COUNTY GENERAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DOMESTIC</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>CLEANING</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>CARROLL</b>	13c. CITY OR TOWN <b>WESTMINSTER</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EUGENE DORSEY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HATTIE WASHINGTON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-03-7793</b>		17. INFORMANT ADDRESS <b>HOSSIE BRIGHTFUL WAYNESBORO PA.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS, RECURRENT</b> <b>4029</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>YEAR</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 WEEKS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>DIABETES MELLITUS SACRAL DECUBITUS SECONDARY INFECTION</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/28</b> , 19 <b>79</b> , to <b>7/19</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>7/19</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Vincent Fiocco Jr.</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/19/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VINCENT FIOCCO JR.</b>		22e. ADDRESS <b>WESTMINSTER MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>July 22 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST JAMES CEM</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>NEW WINDSOR CARROLL MD</b>					
24. FUNERAL DIRECTOR NAME <b>John H. Smith</b>		ADDRESS <b>NEW WINDSOR MD</b>		25a. DATE REC'D BY REGISTRAR <b>JUL 23 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Robert M. Broad</b>	

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